GROUP LIFE CLAIM KIT
FOR PROCESSING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS

INSTRUCTIONS FOR FILING A LIFE CLAIM

PLEASE SUBMIT THE FOLLOWING:

1. THE CLAIM FORM (PAGE 2) FULLY COMPLETED BY THE EMPLOYER AND THE NAMED BENEFICIARY AND SIGNED WHERE INDICATED.

2. A CERTIFIED COPY OF THE DEATH CERTIFICATE OF THE INSURED.

3. THE ORIGINAL ENROLLMENT CARD COMPLETED BY THE INSURED ON WHICH THE BENEFICIARY DESIGNATION HAS BEEN MADE AS WELL AS ANY CHANGE OF BENEFICIARY STATEMENTS. THE ORIGINAL FORMS MUST BE SUBMITTED. PHOTOCOPIES ARE NOT ACCEPTABLE.

4. THE INSURANCE CERTIFICATE ISSUED TO THE INSURED, IF AVAILABLE.

5. IF CLAIM IS BEING MADE FOR ACCIDENTAL DEATH BENEFITS, THEN PAGE 3 MUST ALSO BE FULLY COMPLETED BY THE NAMED BENEFICIARY. APPLICABLE POLICE REPORTS AND NEWSPAPER ARTICLES SHOULD ALSO BE ATTACHED.

6. HIPAA AUTHORIZATION FORM SHOULD BE FULLY COMPLETED BY THE NAMED BENEFICIARY OR NEXT OF KIN IF NAMED BENEFICIARY IS NOT NEXT OF KIN.

INSTRUCTIONS FOR FILING A DEPENDENT LIFE CLAIM

PLEASE SUBMIT THE FOLLOWING:

1. THE CLAIM FORM (PAGE 4) FULLY COMPLETED BY THE EMPLOYER AND THE NAMED BENEFICIARY AND SIGNED WHERE INDICATED.

2. A CERTIFIED COPY OF THE DEATH CERTIFICATE OF THE DEPENDENT.

3. A PHOTOCOPY OF THE ORIGINAL ENROLLMENT CARD COMPLETED BY THE INSURED WHICH INDICATES THAT DEPENDENT COVERAGE HAS BEEN ELECTED.

4. HIPAA AUTHORIZATION FORM SHOULD BE FULLY COMPLETED BY THE NAMED BENEFICIARY OR NEXT OF KIN IF NAMED BENEFICIARY IS NOT NEXT OF KIN.

IF YOU SHOULD NEED ASSISTANCE IN THE COMPLETION OF THE CLAIM FORM
PLEASE CALL (800) 669-2668 EXT. 417

CL1 (W)
Rev 3/06
Expires 3/08

Please see Fraud Notice

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL ST, CANTON MA 02021
781-828-7000 or 1-800-669-2668

Group Life Claim

Employer's Statement

Name of Insured: _____ Group Policy No: _____ Div: _____

Is Insured known by any other name: ☐ Yes ☐ No If yes, please advise: _____

Address of Insured: _____ Certificate No: _____

Date Insured Last Worked: _____ Date of Death: _____ Amount of Insurance: _____

No. of Hours worked each week: _____ Annual Earnings as of date last worked: _____

Reason for leaving work: Disability ☐ Resignation ☐ Vacation ☐ Leave of Absence ☐
Retired ☐ Lay Off ☐ Dismissed ☐ Other _____ (Specify)

Was Insured an Employee at time of death? _____ Insured's Occupation: _____

Date Employed: _____ Date of Birth: _____ Effective Date of Insurance: _____

Was Insurance terminated prior to death? _____ If so, date of termination and reason: _____

I hereby certify that the date through which premium for this Insured has been paid is: _____ (mo-day-yr)

_____
Signature of Authorized Representative

_____
Employer

_____
Street City/Town State Zip

_____
Area Code Telephone Ext.

Beneficiary's Statement (If more than one beneficiary, kindly attach an additional beneficiary statement)

Name of Beneficiary stated on Latest designation by Employer | Date of Birth | Beneficiary's Social Security No. | Relationship

Address of Beneficiary

Street City/Town State Zip

Certification – Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

Signature of Beneficiary _____ Date _____

Expires 3/08

ACCIDENTAL DEATH CLAIM

Beneficiary must **fully** complete this section if claiming an Accidental Death Benefit.

Insured's Name: _____

Date and time of accident causing death: Place of death: Highway ☐ Home ☐

_____20__ _____a.m. _____p.m. Work ☐ Recreation ☐ Other _____

Describe Accident in detail (Please send copies of police reports, newspaper articles etc. to help in the processing of this claim)

_____

_____

_____

_____

_____

Names of PHYSICIANS and/or HOSPITALS where Insured received treatment.

Name	Address
_____	_____
_____	_____
_____	_____

Was Autopsy Performed? ☐ Yes ☐ No If yes, by whom, where, and date.

Name	Address	Date
_____	_____	_____

Expires 3/08

GROUP DEPENDENT LIFE CLAIM

Employers' Statement

Name of Insured: _____ Group Policy No: _____ Div: _____

Is Insured known by any other name: Yes ☐ No ☐ If yes, please advise: _____

Certificate No: _____ Social Security No: _____ Amount of Insurance: _____

Name of Dependent: _____ Date of Birth_____ Date of Death: _____
(mo-day-yr) (mo-day-yr)

Address of Dependent: _____
Street City/Town State Zip

Effective date of Insurance: _____ (mo-day-yr)

Was Insurance terminated prior to death? Yes ☐ No ☐

If yes, Date Terminated: _____ (mo-day-yr)

I hereby certify that the date through which premium for this Insured has been paid is: _____
(mo-day-yr)

_____
Signature of Authorized Representative

_____
Employer

_____
Street City/Town State Zip

_____
Area Code Telephone Ext.

Beneficiary's Statement

Name of Beneficiary | Date of Birth | Beneficiary's Social Security No. | Relationship

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Address of Beneficiary

Street City/Town State Zip

Certification – Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

Signature of Beneficiary _____ Date _____

Expires 3/08

LIFE INSURANCE PAYMENT OPTIONS

Please review the following payment options then check off the box next to the option that you wish to receive. Please sign the form and return to Boston Mutual Life Insurance with your claim.
Should you have any questions, the Claim Department may be reached by calling 1-800-669-2668.

❑ **Lump sum payment.**

❑ **The payee receives sum payable as monthly income for a fixed number of years. The payee leaves the sum payable with us and chooses the number of years, up to 20, to receive monthly income. We will pay an income once a month for the number of years chosen and the first payment as of the payment option date. The amount of each payment is shown in the table below.**

YEARS	PAYMENT	YEARS	PAYMENT
1	84.28	11	8.64
2	42.66	12	8.02
3	28.79	13	7.49
4	21.86	14	7.03
5	17.70	15	6.64
6	14.93	16	6.30
7	12.95	17	6.00
8	11.47	18	5.73
9	10.32	19	5.49
10	9.39	20	5.27

Date: _____ Signature of Beneficiary _____

Policy Number: _____ Insured's Name:_____

Expires 3/08

BOSTON MUTUAL LIFE INSURANCE COMPANY REQUIRED FRAUD NOTICES
For use with Claim Forms

STANDARD NOTICE:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to California residents:
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Residents:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to Florida Residents:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Maine Residents:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines or a denial of insurance benefit.

Notice to New Jersey Residents:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New York Residents (Only applies to A&H):
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Oregon Residents:
Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to Puerto Rico Residents:
Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if mitigating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice to Virginia Residents:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material may have violated state law.

Washington
Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application of insurance may be guilty of a criminal offense under state law.

Additional Beneficiary Statement

Name of Insured: _____ **Policy #: _____**

Beneficiary's
Name _____

Beneficiary's
Social Security No._____

Beneficiary's
Date of Birth _____

Beneficiary's
Telephone No._____

Beneficiary's Address: _____

Certification–Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

X_____/_____/_____
Signature of Beneficiary Printed Signature Date

Beneficiary's
Name _____

Beneficiary's
Social Security No._____

Beneficiary's
Date of Birth _____

Beneficiary's
Telephone No._____

Beneficiary's Address: _____

Certification–Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

X_____/_____/_____
Signature of Beneficiary Printed Signature Date

Beneficiary's
Name _____

Beneficiary's
Social Security No._____

Beneficiary's
Date of Birth _____

Beneficiary's
Telephone No._____

Beneficiary's Address: _____

Certification–Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

X_____/_____/_____
Signature of Beneficiary Printed Signature Date

Expires 3/08